STATEMENT OF EMERGENCY

907 KAR 1:013E

(1) This emergency administrative regulation is being promulgated to amend inpatient DRG-based hospital reimbursement to comply with 2006 Ky Acts ch. 252, KRS 142.303 and 205.638.

(2) This action must be taken on an emergency basis to comply with 2006 Ky Acts ch. 252.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

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Ernie Fletcher
Governor

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Mark Birdwhistell, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Hospital and Provider Operations

(Emergency Amendment)

907 KAR 1:013E. Diagnostic-related group (DRG) inpatient hospital reimbursement [~~Payments for hospital inpatient services~~].

RELATES TO: KRS 13B.140, 205.510(16), 205.565, 205.637, 205.638, 205.639, 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 447.201(c), 447.250-447.280, 42 U.S.C. 1395f(l), ww(d)(5)(F), x(mm), 1396a, 1396b, 1396d, 1396r-4

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 205.637(3), 205.205.640(1), 205.641(2), 216.380(12), 42 C.F.R. 447.200, 447.250, 447.252, 447.253, 447.271, 447.272, 42 U.S.C. 1396a, 1396r-4[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method

for determining the amount payable via a diagnostic related group methodology by the Medicaid Program for a hospital inpatient service including provisions necessary to enhance reimbursement pursuant to KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.

Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

(2) “Appalachian Regional Hospital System” means a private, not-for-profit hospital chain operating in a Kentucky county that receives coal severance tax proceeds.

(3)[~~"Arithmetic mean" means the sum of all values in a set of values divided by the number of values.~~

~~(3)~~] "Base rate" means the per discharge hospital-specific DRG rate for [~~operating and capital-related components for~~] an acute care hospital that is multiplied by the relative weight to calculate the DRG base payment.

(4) "Base year" means the state fiscal year period used to establish DRG rates.

(5) “Base year Medicare rate components” means Medicare inpatient prospective payment system rate components in effect on October 1 during the base year as listed in the CMS IPPS Pricer Program.

(6) [~~cost reporting period upon which a rate is based.~~]

~~(5) "Budget neutrality" means that reimbursements resulting from rates paid to providers under a per discharge or per diem methodology do not exceed payments in the prior year adjusted for inflation based on the CMS Input Price Index, changes in patient utilization.~~

~~(6)~~] "Budget neutrality factor" means a factor that is applied to a DRG base rate[~~relative weight per~~ ~~diem rate~~] or the direct graduate medical educational payment so that budget neutrality is achieved.

(7) “Capital cost” means capital related expenses including insurance, taxes, interest and depreciation related to plant and equipment.

(8) “CMS” means the Centers for Medicare and Medicaid Services.

(9) “CMS IPPS Pricer Program” means the software program published on the CMS website of http://www.cms.hhs.gov which shows the Medicare rate components and payment rates under the Medicare inpatient prospective payment system for a discharge within a given federal fiscal year.

(10) “Cost center specific cost-to-charge ratio” means a ratio of a hospital’s cost center specific total hospital costs to its cost center specific total charges.

(11) “Cost outlier” means a claim for which estimated cost exceeds the outlier threshold.

(12)[~~(7) "Capital costs" means capital related expenses including insurance, taxes, interest, and depreciation related to plant and equipment.~~

~~(8) "CMS" means Centers for Medicare and Medicaid Services.~~

~~(9) "CMS Input Price Index" means the wage index published by CMS in the Federal Register.~~

~~(10) "Cost basis" means the allowable Medicaid inpatient costs incurred by a provider in a base year, which are the sum of routine Medicaid costs determined by applying each hospital’s routine per diem amount to the allowed patient days in the base year and ancillary Medicaid costs determined by applying ancillary costs-to-charge ratios derived from base year cost reports to ancillary charges for that hospital’s Medicaid claims with dates of service in the base year.~~

~~(11) "Cost outlier" means a claim which has an operating cost which is $29,000~~

~~greater than a Medicare DRG's outlier threshold.~~

~~(12) "Countable resource" means cash or an asset readily convertible to cash including a checking account, savings account, stock, bond, mutual fund, certificate of deposit, money market account, or similar financial instrument.~~

~~(13)~~] "Critical access hospital" or "CAH" means a hospital meeting the licensure requirements established in 906 KAR 1:110, Critical access hospital services.

(13)[~~(14)~~] "Department" means the Department for Medicaid Services or its designated agent.

(14) "Diagnostic categories" means the diagnostic classifications containing one or more DRGs used by Medicare programs, assigned in the base year with modifications established in Section 2(15) of this administrative regulation.

(15) "Diagnostic related group" or "DRG" means a clinically-similar grouping of services that can be expected to consume similar amounts of hospital resources.

(16) [~~"Disproportionate share hospital" or "DSH" means a hospital that:~~

~~(a) Has an inpatient Medicaid utilization rate of one (1) percent or higher; and~~

~~(b) Meets the criteria established in 42 U.S.C. 1396r-4(d).~~

~~(17)~~] "Distinct part unit" means a separate unit within an acute care hospital that meets the qualifications established in 42 C.F.R. 412.25.

(17) "DRG average length of stay" means the Kentucky arithmetic mean length of stay for each DRG, calculated by dividing the sum of patient days in the base year claims data for each DRG by the number of discharges for each DRG.

(18) "DRG base payment" means the base payment for claims paid under the DRG methodology.

(19) “Federal financial participation” means funding from the Centers for Medicare and Medicaid Services.

(20)[~~(18) "DRI" means Data Resources, Incorporated.~~

~~(19) "Federal Register" means the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as executive orders and other presidential documents.~~

~~(20)~~] "Fixed loss cost threshold" means the amount, equal to $29,000, which is combined with the full DRG payment or transfer payment for each DRG to determine the outlier threshold.

(21) “Geometric mean” means the measure of central tendency for a set of values expressed as the n^{th} (number of values in the set) root of their product.

(22) “GII” means Global Insight, Incorporated.

(23)[~~(21)~~] "Government entity" means an entity that qualifies as a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).

(24) “High intensity level II neonatal center” means an in-state hospital with a level II neonatal center which:

(a) Is licensed for a minimum of twenty-four (24) neonatal level II beds;

(b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;

(c) Has a gestational age lower limit of twenty-seven (27) weeks; and

(d) Has a full-time perinatologist on staff.

(25) “High volume per diem payment” means a per diem add-on payment made to hospitals meeting selected Medicaid utilization criteria established in Section 2(12) of this administrative regualtion.

(26)[~~(22)~~] "Indexing factor" means the percentage that the cost of providing a service is expected to increase during the universal rate year.

(27)[~~(23) "Indigent care" means the unreimbursed cost to a hospital of providing a service on an inpatient or outpatient basis:~~

~~(a) To an individual who is:~~

~~1. Determined to be indigent in accordance with KRS 205.640; and~~

~~2. Not a Medicaid recipient; and~~

~~(b) For which an individual shall not be billed by the hospital.~~

~~(24) "Indigent care eligibility criteria" means the criteria as specified in Section 25 of this administrative regulation used by a hospital to determine if an individual is eligible for indigent care.~~

~~(25)~~] "Inflation factor" means the percentage that the cost of providing a service has increased, or is expected to increase, for a specific period of time.

(28)[~~(26)~~] "Intrahospital transfer" means a transfer within the same acute care hospital resulting in a discharge from and a new admission to a licensed and certified acute care bed, psychiatric distinct part unit, or rehabilitation distinct part unit.

(29)[~~(27)~~] "Level II neonatal center" means a facility with a licensed level II bed which [~~that~~] provides specialty care for infants which includes monitoring for apnea spells, incubator or other assistance to maintain the infant's body temperature, and feeding assistance.

(30)[~~(28)~~] "Level III neonatal center" means a facility with a licensed level III bed which provides specialty care of infants which includes ventilator or other respiratory assistance for infants who cannot breathe adequately on their own, special intravenous

catheter to monitor and assist blood pressure and heart function, observation and monitoring of conditions that are unstable or may change suddenly, and postoperative care.

(31)[~~(29)~~] "Long-term acute care hospital" [~~or "LTAC"~~] means a hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(32)[~~(30)~~] "Medicaid shortfall" means the difference between a provider's cost of providing services to Medicaid recipients and the amount received in accordance with the payment provisions established in Section 2 of this administrative regulation and 907 KAR 1:820, Disproportionate share hospital distributions [~~in Sections 3, 11, and 23 of this~~ ~~administrative regulation~~].

(33)[~~(31)~~] "Medical education costs" means direct costs that are:

(a) Associated with an approved intern and resident program; and

(b) Subject to limits established by Medicare.

(34)[~~(32)~~] "Medically necessary" or "medical necessity" means that a covered benefit shall be provided in accordance with 907 KAR 3:130, Medical necessity and clinically appropriate determination basis.

(35)[~~(33) "Operating costs" means allowable routine, ancillary service and special care unit costs related to inpatient hospital services.~~

~~(34)~~] "Outlier threshold" means the sum of the DRG base payment or transfer payment [~~operating payment amount, capital-related payment amount,~~] and the fixed loss cost threshold.

(36)[~~(35)~~] "Pediatric teaching hospital" is defined in KRS 205.565(1).

(37)[~~(36)~~] "Per diem rate" means the per diem rate paid by the department for inpatient care in an in-state psychiatric or rehabilitation hospital, inpatient care in a long-

term acute care hospital, inpatient care in a critical access hospital or psychiatric or rehabilitation services in an in-state acute care hospital which has a distinct part unit.

(38) [~~effective April 1, 2003, for rehabilitation hospitals, long-term acute care hospitals, critical access hospitals, psychiatric hospitals, and psychiatric services provided in an acute care hospital~~.

~~(37) "Price level increase" means the percentage that the cost of providing a service has increased, or is expected to increase, for a specific period of time.~~

~~(38) "Professional component cost" means a physician compensation cost paid by the provider for a psychiatric service to a patient in a psychiatric hospital.~~

~~(39) "Psychiatric access hospital" means an acute care hospital which:~~

~~(a) Is not located in a Metropolitan Statistical Area as determined by the U.S. Census Bureau;~~

~~(b) Provides at least 65,000 days of inpatient care in a fiscal year;~~

~~(c) Provides at least twenty (20) percent of inpatient care to Medicaid eligible recipients; and~~

~~(d) Provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.~~

~~(40)~~] "Psychiatric hospital" means a hospital which meets the licensure requirements as established in 902 KAR 20:180, Psychiatric hospitals; operation and services.

(39)[~~(41)~~] "Quality improvement organization" or "QIO" means an organization that complies with 42 C.F.R. 475.101.

(40)[~~(42)~~] "Rebase" means to redetermine base rates, per diem rates, and other applicable components of the payment rates using more recent data.

(41)[~~(43)~~] "Rehabilitation hospital" means a hospital meeting the licensure requirements as established in 902 KAR 20:240, Comprehensive physical rehabilitation hospital services.

(42)[~~(44)~~] "Relative weight" means the factor assigned to each Medicare DRG classification that represents the average resources required for a Medicare DRG classification relative to the average resources required for all relevant discharges in the state.

(43)[~~(45)~~] "Resident" means an individual living in Kentucky who is not receiving public assistance in another state.

(44) “Rural hospital” means a hospital located in a rural area pursuant to 42 CFR 412.64(b)(1)(C).

(45)[~~(46)~~] "State university teaching hospital" means:

(a) A hospital that is owned or operated by a Kentucky state-supported university with a medical school; or

(b) A hospital:

1. In which three (3) or more departments or major divisions of the University of Kentucky or University of Louisville medical school are physically located and which are used as the primary (greater than fifty (50) percent) medical teaching facility for the medical students at the University of Kentucky or the University of Louisville; and

2. That does not possess only a residency program or rotation agreement.

(46) “Transfer payment” means a payment made for a recipient who is transferred to or from another hospital for a service reimbursed on a prospective discharge basis.

(47)[~~(47) "Third-party payor" means a payor of a third party pursuant to KRS 205.510(16).~~

~~(48)~~] "Trending factor" means the inflation factor as applied to that period of time between a facility's base fiscal year end and the beginning of the universal rate year.

(48)[~~(49 "Type I hospital" means an in-state disproportionate share hospital with 100 beds or less that participates in the Medicaid Program.~~

~~(50) "Type II hospital" means an in-state disproportionate share hospital with 101 beds or more that participates in the Medicaid Program, except for a hospital that meets the criteria established in this administrative regulation for a Type III or Type IV hospital.~~

~~(51)~~] "Type III hospital" means an in-state disproportionate share state university teaching hospital, owned or operated by either the University of Kentucky or the University of Louisville Medical School.

(49)[~~(52) "Type IV hospital" means an in-state disproportionate share hospital participating in the Medicaid Program that is a state-owned psychiatric hospital.~~

~~(53)~~] "Universal rate year" means the twelve (12) month period under the prospective payment system, beginning July of each year, for which a payment rate is established for a hospital regardless of the hospital's fiscal year end.

(50) "Urban hospital" means a hospital located in an urban area pursuant to 42 CFR 412.64(b)(1)(ii).

(51)[~~(54) "Upper payment limit" means the maximum amount the Medicaid Program shall pay for an inpatient day of care with the maximum varying based on the following:~~

~~(a) Utilization;~~

~~(b) Peer grouping; and~~

~~(c) Age of patient.~~

~~(55)~~] "Urban trauma center hospital" means an acute care hospital that:

(a) Is designated as a Level I Trauma Center by the American College of Surgeons;

(b) Has a Medicaid utilization rate greater than twenty-five (25) percent; and

(c) At least fifty (50) percent of its Medicaid population are residents of the county in which the hospital is located.

[~~(56) "Weighted median" means the cost per diem associated with the median point of cumulative inpatient days calculated by arraying cost per diems within a specified peer group from lowest to highest.~~]

Section 2. [~~Reimbursement for an Inpatient Hospital Service. The department shall reimburse for an inpatient hospital service provided to an eligible Medicaid recipient through the use of a rate that meets the requirements of 42 U.S.C. 1396a(a)(13).~~

~~Section 3.~~]Payment for an Inpatient Acute Care Service in an <u>In-state</u> Acute Care Hospital. (1) An <u>in-state</u> acute care hospital shall be paid for an inpatient acute care service on a fully-prospective per discharge basis [~~for the universal rate year beginning on or after April 1, 2003~~].

(2) For an inpatient acute care service in an <u>in-state</u> acute care hospital, the total <u>hospital-specific</u> per discharge payment shall be the sum of:

(a) <u>A DRG base payment;</u>

<u>(b) If applicable, a high volume per diem payment; and</u>

<u>(c) If applicable, a cost outlier payment amount.</u>

<u>(3)(a) A DRG shall be based on the Medicare grouper in effect in the Medicare inpatient prospective payment system at the time of rebasing.</u>

<u>(b) For a rate effective upon the effective date of this administrative regulation, the department shall assign to the base year claims data, DRG classifications from Medi-</u>

care grouper version twenty-four (24) effective in the Medicare inpatient prospective payment system as of October 1, 2006.

(4) A DRG base payment shall be calculated for a discharge by multiplying the hospital specific base rate by the DRG relative weight.

(5)(a) The department shall determine a base rate by calculating a case mix, outlier payment and budget neutrality adjusted cost per discharge for each in-state acute care hospital as described in subsection (5) through (10) of this Section.

(b) A hospital specific cost per discharge used to calculate a base rate shall be based on base year inpatient paid claims data.

(c) For a rate effective upon the effective date of this administrative regulation, a hospital specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data.

(6)(a) The department shall calculate a cost to charge ratio for the fifteen (15) Medicaid and Medicare cost centers displayed in Table 1 below.

(b) If a hospital lacks cost-to-charge information for a given cost center or if the hospital's cost-to-charge ratio is above or below three (3) standard deviations from the mean of a log distribution of cost-to-charge ratios, the department shall use the statewide geometric mean cost-to-charge ratio for the given cost center.

Table 1. Kentucky Medicaid Cost Center to Medicare Cost Report Cost Center Crosswalk

Kentucky Medicaid Cost Center	Kentucky Medicaid Cost Center Description	Medicare Cost Report Standard Cost

		Center
1	Routine Days	25
2	Intensive Days	26, 27, 28, 29, 30
3	Drugs	48, 56
4	Supplies or equipment	55, 66, 67
5	Therapy services excluding inhalation therapy	50, 51, 52
6	Inhalation therapy	49
7	Operating room	37, 38
8	Labor and delivery	39
9	Anesthesia	40
10	Cardiology	53, 54
11	Laboratory	44, 45
12	Radiology	41, 42
13	Other services	43, 46, 47, 57, 58, 59, 60, 61, 62, 63, 63.5, 64, 65, 68
14	Nursery	33
15	Neonatal intensive days	30

(7)(a) For a hospital with an intern or resident reported on its Medicare cost report, the department shall calculate allocated overhead by computing the difference between the costs of interns and residents before and after the allocation of overhead costs.

(b) The ratio of overhead costs for interns and residents to total facility costs shall be multiplied by the costs in each cost center prior to computing the cost center cost-to-charge ratio.

(8) For an in-state acute care hospital, the department shall compile the number of patient discharges, patient days and total charges from the base year claims data. The department shall exclude from the rate calculation:

(a) Claims paid under a managed care program;

(b) Claims for rehabilitation and psychiatric discharges reimbursed on a per diem basis;

(c) Transplant claims; and

(d) Revenue codes not covered by the Medicaid program.

(9)(a) The department shall calculate the cost of a base year claim by multiplying the charges from each accepted revenue code by the corresponding cost center specific cost-to-charge ratio.

(b) The department shall base cost center specific cost-to-charge ratios on data extracted from the most recently, as of June 1, finalized cost report.

(c) Only an inpatient revenue code recognized by the department shall be included in the calculation of estimated costs.

(10) Using the base year Medicaid claims referenced in subsection (8) of this Section, the department shall compute a hospital specific cost per discharge by dividing a hospital's Medicaid costs by its number of Medicaid discharges.

(11) The department shall determine an in-state acute care hospital's DRG base payment rate by adjusting the hospital's specific cost per discharge by the hospital's

case mix, expected outlier payments and budget neutrality.

(a)1. A hospital's case mix adjusted cost per discharge shall be calculated by dividing the hospital's cost per discharge by its case mix index; and

2. The hospital's case mix index shall be equal to the average of its DRG relative weights for acute care services for base year Medicaid discharges referenced in sub-section (8) of this Section.

(b)1. A hospital's case mix adjusted cost per discharge shall be multiplied by an initial budget neutrality factor.

2. The initial factor for a state fiscal year 2007 rate shall be 0.6962 for all hospitals.

3. When rates are rebased, the initial budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.

(c)1. Each hospital's case mix and initial budget neutrality adjusted cost per discharge shall be multiplied by a hospital-specific outlier payment factor.

2. A hospital-specific outlier payment factor shall be the result of the following formula: ((expected DRG non-outlier payments) – (expected proposed DRG outlier payments))/(expected DRG non-outlier payments).

(d)1. A hospital's case mix, initial budget neutrality and outlier payment adjusted cost per discharge shall be multiplied by a secondary budget neutrality factor.

2. The secondary factor for a hospital for state fiscal year 2007 shall be 1.0744.

3. When rates are rebased, the secondary budget neutrality factor shall be calculated so that total payments in the rate year shall be equal to total payments in the prior

year plus inflation for the upcoming rate year and adjusted to eliminate changes in patient volume and case mix.

(12)(a) The department shall make a high volume per diem payment to an in-state acute care hospital with high Medicaid volume for base year covered Medicaid days referenced in subsection (8) of this Section.

(b) High volume per diem criteria shall be based on the number of Kentucky Medicaid days or the hospital's Kentucky Medicaid utilization percentage.

(c)1. A high volume per diem payment shall be made in the form of a per diem add-on amount in addition to the DRG base payment rate encompassing the DRG average length-of-stay days per discharge.

2. The payment shall be equal to the applicable high volume per diem add-on amount multiplied by the DRG average length-of-stay associated with the claim's DRG classification.

(d)1. The department shall determine a per diem payment associated with Medicaid days-based criteria separately from a per diem payment associated with Medicaid utilization-based criteria.

2. If a hospital qualifies for a high volume per diem payment under both the Medicaid days-based criteria and the Medicaid utilization-based criteria, the department shall pay the higher of the two add-on per diem amounts.

(e) The department shall pay the indicated high volume per diem payment if either the estimated Kentucky Medicaid inpatient days or Kentucky Medicaid inpatient days utilization meet the criteria established in Table 2 below:

Table 2 – High Volume Adjustment Eligibility Criteria			
Kentucky Medicaid Inpatient Days		Kentucky Medicaid Inpatient Days Utilization	
Days Range	Per Diem Payment	Medicaid Utilization Range	Per Diem Payment
3,000 – 4,200 days	$40 per day	19.3% - 20%	$50 per day
4,200 – 5,600 days	$60 per day	20.1% - $27.2%	$115 per day
5,600 – 9,000 days	$100 per day	27.3% - and above	$125 per day
9,000 – 20,000 days	$125 per day		
20,000 days and above	$205 per day		

(f)1. The department shall use base year claims data referenced in subsection (8) of this Section to determine if a hospital qualifies for a high volume per diem add-on payment.

2. The department shall determine Kentucky Medicaid inpatient days for a hospital by multiplying the DRG classification for each base year claim by the corresponding Kentucky DRG average length of stay.

(g) The department shall only change a hospital's classification regarding a high volume add-on payment or per diem amount during a rebasing year.

(13)(a) The department shall make an additional cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each diagnostic category.

(b) A cost outlier shall be subject to QIO review and approval.

(c) A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.

(d)1. The department shall calculate the estimated cost of a discharge, for purposes of comparing the discharge cost to the outlier threshold, by multiplying the sum of the hospital specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.

2. A Medicare operating or capital-related cost-to-charge ratio shall be extracted from the CMS IPPS Pricer Program.

(e)1. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.

2. The fixed loss cost threshold shall equal $29,000.

(f) A cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.

(14) The department shall calculate a Kentucky Medicaid-specific DRG relative weight by:

(a)1. Selecting Kentucky base year Medicaid inpatient paid claims, excluding those described in subsection (8) of this Section; and

2. For a rate effective upon the effective date of this administrative regulation, a hospital-specific cost per discharge shall be calculated using state fiscal year 2006 inpatient Medicaid paid claims data;

(b)1. Reassigning the DRG classification for the base year claims based on the Medicare DRG in effect in the Medicare inpatient prospective payment system at the time of rebasing; and

2. For a rate effective upon the effective date of this administrative regulation, the department shall assign to the base year claims data the Medicare grouper version 24 DRG classifications which were effective in the Medicare inpatient prospective payment system as of October 1, 2006;

(c) Removing the following claims from the calculation:

1. Claims data for a discharge reimbursed on a per diem basis including:

a. A psychiatric claim, defined as follows:

(i) An acute care hospital claim with a psychiatric DRG;

(ii) A psychiatric distinct part unit claim; and

(iii) A psychiatric hospital claim;

b. A rehabilitation claim, defined as follows:

(i) An acute care hospital claim with a rehabilitation DRG;

(ii) A rehabilitation distinct part unit claim; and

(iii) A rehabilitation hospital claim;

c. A critical access hospital claim; and

d. A long term acute care hospital claim;

2. A transplant service claim as specified in subsection (19) of this Section;

3. A claim for a patient discharged from an out-of-state hospital; and

4. A claim with total charges equal to zero (0);

(d) Calculating a relative weight value for a low volume DRG by:

1.a. Arraying a DRG with less than twenty-five (25) cases in order by the Medicare DRG relative weight in effect in the Medicare inpatient prospective payment system at the same time as the Medicare DRG grouper version, published in the Federal Regis-

ter, relied upon for Kentucky DRG classifications; and

b. For a rate rate effective upon the effective date of this administrative regulation, the department shall use the Medicare DRG relative weight which was effective in the Medicare inpatient prospective payment system as of October 1, 2006;

2. Grouping a low volume DRG, based on the Medicare DRG relative weight sort, into one (1) of five (5) categories resulting in each category having approximately the same number of Medicaid cases;

3. Calculating a DRG relative weight for each category; and

4. Assigning the relative weight calculated for a category to each DRG included in the category;

(e)1. Standardizing the labor portion of the cost of a claim for differences in wage and the full cost of a claim for differences in indirect medical education costs across hospitals based on base year Medicare rate components;

a. For a rate effective upon the effective date of this administrative regulation, base year Medicare rate components shall equal Medicare rate components effective in the Medicare inpatient prospective payment system as of October 1, 2005; and

b. Base year Medicare rate components used in the Kentucky inpatient prospective payment system include:

(i) Labor-related percentage and non-labor-related percentage;

(ii) Operating and capital cost-to-charge ratios;

(iii) Operating indirect medical education costs; or

(iv) Wage indices;

2.a. The department shall standardize costs using the following formula: standard

cost = [((labor related percentage X costs)/Medicare wage index) + (non-labor related percentage X costs)]/(1 + Medicare operating indirect medical education factor); and

b. For a rate effective upon the effective date of this administrative regulation, the labor related percentage shall equal sixty-two (62) percent and the non-labor related percentage shall equal thirty-eight (38) percent;

(f) Removing statistical outliers by deleting any case that is:

1. Above or below three (3) standard deviations from the mean cost per discharge; and

2. Above or below three (3) standard deviations from the mean cost per day;

(g) Computing an average standardized cost for all DRGs in aggregate and for each DRG, excluding statistical outliers;

(h) Computing DRG relative weights:

1. For a DRG with twenty-five (25) claims or more by dividing the average cost per discharge for each DRG by the statewide average cost per discharge; and

2. For a DRG with less than twenty-five (25) claims by dividing the average cost per discharge for each of the five (5) low volume DRG categories by the statewide average cost per discharge; and

(i) Calculating, for the purpose of a transfer payment, Kentucky Medicaid geometric mean length of stay for each DRG based on the base year claims data used to calculate DRG relative weights.

(15) The department shall:

(a) Separately reimburse for a mother’s stay and a newborn’s stay based on the diagnostic category assigned to the mother’s stay and to the newborn’s stay;

(b) Establish a unique set of diagnostic categories and relative weights for an in-state acute care hospital identified by the department as qualifying as a level II or a level III neonatal center as follows:

1. The department shall reassign a claim that would have been assigned to a Medicare DRG 385-390 to a Kentucky-specific:

a. DRG 675-680 for an in-state acute care hospital with a level II neonatal center; and

b. DRG 685-690 for an in-state acute care hospital with a level III neonatal center;

2. The department shall assign a DRG 385-390 for a neonatal claim from a hospital which does not operate a level II or III neonatal center; and

3.a. The department shall compute a separate relative weight for a level II or III neonatal intensity care unit (NICU) neonatal DRG;

b. The department shall use base year claims from level II neonatal centers to calculate relative weights for DRGs 675-680; and

c. The department shall use base year claims from level III neonatal centers to calculate relative weights for DRGs 685-690.

(16) [~~An operating payment amount;~~

~~(b) A capital-related payment amount; and~~

~~(c) If applicable, a cost outlier payment amount.~~

(~~3) An operating payment amount shall be based on a patient's DRG classification, as assigned by the Medicare DRG classification system, subject to the modification described in subsection (6) of this section. The operating payment amount shall be calculated for each discharge by multiplying a hospital's operating base rate by the Medicaid-~~

~~specific DRG relative weight.~~

~~(4) The operating base rate for each hospital shall be the Medicare national standardized amount as adjusted by Medicare for each hospital using the Medicare wage index and Medicare indirect medical education operating adjustment factor.~~

~~(a) The Medicare DSH operating adjustment factor shall be excluded from the calculation of the operating base rate for each hospital.~~

~~(b) The adjusted Medicare national standardized amount shall be calculated based on the Medicare rate data published in the Federal Register for Medicare payments effective on October 1 of the year immediately preceding the universal rate year.~~

~~(c) Data not specifically available in the Federal Register shall be obtained from each hospital's Medicare fiscal intermediary.~~

~~(5) A capital-related payment amount shall be based on a patient's DRG classification, as assigned by the Medicare DRG classification system, subject to the modification described in subsection (6) of this section. The capital payment amount shall be calculated for each discharge by multiplying a hospital's capital-related base rate by the Medicaid-specific DRG relative weight.~~

~~(6) The capital-related base rate for each hospital shall be the Medicare federal capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor if applicable, the Medicare geographic adjustment factor, and the Medicare indirect medical education capital adjustment factor published in the Federal Register.~~

~~(a) The Medicare DSH capital adjustment factor shall be excluded from the calculation of the capital-related base rate for each hospital.~~

~~(b) For each universal rate year beginning July 1, 2004, the adjusted Medicare federal capital rate shall be calculated based on the Medicare rate data published in the Federal Register for Medicare payments effective on October 1 of the year immediately preceding the universal rate year.~~

~~(c) Data not specifically available in the Federal Register shall be obtained from each hospital's Medicare fiscal intermediary.~~

~~(7) An additional cost outlier payment shall be made for an approved discharge meeting the Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to QIO review and approval.~~

~~(a) A discharge shall qualify for an additional cost outlier payment if its estimated cost exceeds the DRG's outlier threshold.~~

~~(b) The estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be calculated by multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the discharge-allowed charges.~~

~~(c) The Medicare operating and capital-related cost-to-charge ratios shall be those used by Medicare published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.~~

~~(d) An outlier threshold shall be calculated as the sum of the discharge's operating payment amount, capital-related payment amount and the fixed loss cost threshold.~~

~~(e) Payment for a cost outlier shall be eighty (80) percent of the amount that estimated costs exceed the discharge's outlier threshold.~~

~~(8) Kentucky Medicaid-specific DRG relative weights shall be calculated using all ap-~~

~~plicable Medicaid discharges from the hospital's base year claims data and determined as follows:~~

~~(a) Medicaid claims from the base year claims data shall be assigned Medicare DRG classifications using the Medicare DRG classification system.~~

~~(b) Claims data for discharges that are reimbursed on a per diem basis shall be removed, including:~~

~~1. Psychiatric claims from all hospitals, identified as those claims from acute care hospitals with psychiatric diagnoses;~~

~~2. All claims from psychiatric hospitals;~~

~~3. All claims from rehabilitation hospitals;~~

~~4. All claims from critical access hospitals; and~~

~~5. All claims from long-term acute care hospitals.~~

~~(c) Claims for transplant services as specified in subsection (13) of this section shall be removed.~~

~~(d) Claims for patients discharged from out-of-state hospitals shall be removed.~~

~~(e) Allowed days for the remaining discharges shall be identified.~~

~~(f) A unique set of DRGs and relative weights shall be established for a facility identified by the department as qualifying as a Level III neonatal center.~~

~~1. A claim classified into DRGs 385 through 390 for a qualifying hospital where care is provided in a neonatal intensive care unit bed shall be identified and reassigned to DRGs 685 through 690, respectively.~~

~~2. Only a qualifying hospital shall be eligible for payment using DRGs 685 through 690.~~

~~(g) A statewide Medicaid arithmetic mean length-of-stay per discharge shall be determined for each DRG classification.~~

~~(h) Relative weights shall be calculated for each DRG by multiplying the Medicare relative weight by the ratio of the Medicaid arithmetic mean length-of-stay to the Medicare arithmetic mean length-of-stay, multiplied by the budget neutrality factor.~~

~~(i) For purposes of calculating the DRG relative weights in paragraph (h) of this subsection, Medicare DRG relative weights and arithmetic mean length-of-stay shall be those published in the Federal Register effective on October 1 of the year immediately preceding the universal rate year.~~

~~(9) An indirect medical education adjustment factor shall be the same indirect medical education factor used by Medicare for Medicare rates effective on October 1 of the year immediately preceding the universal rate year.~~

~~(a) An indirect medical education operating adjustment factor shall be the same used by Medicare, based on the published Medicare formula. The ratio of intern and residents to available beds used in the Medicare formula shall be obtained from each hospital's Medicare fiscal intermediary.~~

~~(b) An indirect medical education capital adjustment factor shall be the same used by Medicare, based on the published Medicare formula. The ratio of intern and residents to average daily census used in the Medicare formula shall be obtained from each hospital's Medicare fiscal intermediary.~~

~~(10)~~] If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.

(a) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount [~~shall be calculated~~] based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

1. The department shall calculate an average daily rate [~~shall be calculated~~] by dividing the DRG base payment [~~allowable per discharge reimbursement amount, based on a patient's DRG classification,~~] by the statewide Medicaid geometric mean [~~average~~] length-of-stay for a patient's DRG classification.

2. If a hospital qualifies for a high volume per diem add-on payment in accordance with Section 2(12) of this administrative regulation, the department shall pay the hospital the applicable per diem add-on for the DRG average length-of-stay. [~~An allowable per discharge reimbursement amount, based on a patient's DRG classification, shall be the sum of the operating payment amount and the capital-related payment amount.~~]

3. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

(b) For a hospital receiving a transferred patient, the department shall reimburse the DRG base payment [~~reimbursement shall be the allowable per discharge reimbursement amount, based on the patient's DRG classification~~], and, if applicable, a high volume per diem add-on amount and a cost outlier payment amount.

(17) The department shall treat [~~(11)~~] a transfer from an acute care hospital to a qualifying postacute care facility for selected DRGs in accordance with paragraph (b) of this

subsection [~~will be treated~~] as a postacute care transfer.

(a) The following shall qualify as a postacute care setting:

1. A psychiatric, rehabilitation, children's, long-term, or cancer hospital;

2. A skilled nursing facility; or

3. A home health agency.

(b) A DRG eligible for a postacute care transfer payment shall be in accordance with 42 USC 1395ww(d)(4)(C)(i).

(c) The department shall pay each transferring hospital an average daily rate for each day of stay. [~~The following DRGs shall be eligible for the postacute care transfer payment:~~

~~1. DRG 14, Specific cerebrovascular disorders except transient ischemic attack;~~

~~2. DRG 113, Amputation for circulatory system disorders except upper limb and toe;~~

~~3. DRG 209, Major joint limb reattachment procedures of lower extremity;~~

~~4. DRG 210, Hip and femur procedures except major joint procedures age > seventeen (17) with CC;~~

~~5. DRG 211, Hip and femur procedures except major joint procedures age > seventeen (17) without CC;~~

~~6. DRG 236, Fractures of hip and pelvis;~~

~~7. DRG 263, Skin graft and debridement for skin ulcer or cellulitis with CC;~~

~~8. DRG 264, Skin graft and debridement for skin ulcer or cellulitis without CC;~~

~~9. DRG 429, Organic disturbances and mental retardation; and~~

~~10. DRG 483, Tracheostomy except for face, mouth and neck diagnoses.~~

~~(c) Each transferring hospital shall be paid a per diem rate for each day of stay.~~]

1. A payment shall not [~~payments shall~~] exceed the full DRG payment [~~not~~] that would have been made if the patient had been discharged without being transferred.

2. A DRG identified by CMS as being eligible for special payment [~~DRGs 209, 210, and 211~~] shall receive fifty (50) percent of the full DRG payment plus the average daily rate [~~per diem~~] for the first day of the stay and fifty (50) percent of the average daily rate [~~per diem~~] for the remaining days of the stay, up to the full DRG base payment.

3. The remaining DRGs as referenced in paragraph (b)[~~(a)~~] of this subsection shall receive twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer.

(d) The per diem amount shall be the base [~~full~~] DRG payment allowed divided by the statewide Medicaid geometric mean [~~average~~] length of stay for a patient's DRG classification [~~that DRG~~].

(18) The department shall reimburse for [~~(12) Effective February 1, 2004,~~] an intra-hospital transfer to or from an acute care bed to or from a rehabilitation or psychiatric distinct part unit [~~shall be reimbursed~~]:

(a) The full DRG base payment allowed; and

(b) The facility-specific distinct part unit per diem rate, in accordance with 907 KAR 1:815, Non-DRG hospital reimbursement, for each day the patient remains in the distinct part unit.

(19)(a) The department shall reimburse for [~~(13)~~] a kidney, cornea, pancreas, or kidney and pancreas transplant [~~shall be reimbursed~~] on a prospective per discharge method according to the patient's DRG classification.

(b) A transplant not referenced in paragraph (a) of this subsection, [~~All other trans-~~

~~plants~~] shall be reimbursed in accordance with 907 KAR 1:350, Coverage and payments for organ transplants.

[~~(14) Payment for a federally-defined hospital swing bed shall be made in accordance with 907 KAR 1:065.~~]

Section 3.[~~4.~~] Preadmission Services for an Inpatient Acute Care Service. A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

(1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and[~~.~~]

(2) Exclude a service furnished by a home health agency, a skilled nursing facility or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

Section 4.[~~5. Payment for~~] Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs. (1) If federal financial participation for direct graduate medical education costs is not provided to the department, pursuant to 42 CFR 447.201(c) or other federal regulation or law, the department shall not reimburse for direct graduate medical education costs.

(2) If federal financial participation for direct graduate medical education costs is provided to the department, [~~(1)~~] the department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as follows:

(a) [~~. (2)~~] A payment shall be made:

1. Separately from the per discharge and per diem payment methodologies; and

2. [~~shall be made~~] On an annual basis; and

(b) The department shall determine an annual payment amount for a [~~. (3) an annual payment amount shall be determined for each~~] hospital as follows:

1.[~~(a)~~] The hospital-specific and national average Medicare per intern and resident amount effective for Medicare payments on October 1 immediately preceding the universal rate year shall be provided by [~~are obtained from~~] each approved hospital's Medicare fiscal intermediary;[~~.~~]

2.[~~(b)~~] The higher of the average of the Medicare hospital-specific per intern and resident amount or the Medicare national average amount shall be selected;[~~.~~]

3.[~~(c)~~] The selected per intern and resident amount shall be multiplied by the hospital's number of interns and residents used in the calculation of the indirect medical education operating adjustment factor. The resulting amount is an estimate of total approved direct graduate medical education costs;[~~.~~]

4.[~~(d)~~] The estimated total approved direct graduate medical education costs shall be divided by the number of total inpatient days as reported in the hospital's most recently finalized [~~Medicaid~~] cost report on Worksheet D, Part 1, to determine an average approved graduate medical education cost per day amount;[~~.~~]

5.[~~(e)~~] The average graduate medical education cost per day amount shall be multiplied by the number of total covered days for the hospital reported in the base year claims data to determine the total graduate medical education costs related to the Medicaid Program; and[~~.~~]

6.[~~(f)~~] Medicaid program graduate medical education costs shall then be multiplied by the budget neutrality factor.

Section 5.[~~6. Payment for Rehabilitation Services in an Acute Care Hospital. (1) Effective February 1, 2004, A rehabilitation service in an acute care hospital that has a Medicare-designated rehabilitation distinct part unit shall be reimbursed on a per diem basis.~~

~~(2) A rehabilitation per diem rate shall be a facility-specific rate based on the most recently received cost report and in accordance with Section 14 of this administrative regulation.~~

~~(3) A rehabilitation service provided in a hospital that does not have a Medicare-designated distinct part unit shall be reimbursed the median of rehabilitation services provided in all acute care hospitals.~~

~~Section 7. Payment for an Inpatient Psychiatric Service in an Acute Care Hospital. (1) Effective February 1, 2004, an inpatient psychiatric service provided in an acute care hospital that has a Medicare-designated psychiatric distinct part unit shall be reimbursed on a per diem basis.~~

~~(2) Reimbursement for an inpatient psychiatric service shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.~~

~~(3) A psychiatric per diem rate shall be the sum of a psychiatric operating per diem rate and a psychiatric capital per diem rate.~~

~~(a) The psychiatric operating cost-per-day amounts used to determine the psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid psychiatric cost basis, excluding capital costs and medical education costs, by the number of Medicaid psychiatric patient days in the base year.~~

~~(b) The Medicaid psychiatric cost basis and patient days shall be based on Medicaid~~

~~claims for patients with a psychiatric diagnosis with dates of service in the base year. The psychiatric operating per diem rate shall be adjusted for:~~

~~1. The price level increase from the midpoint of the base year to the midpoint of the universal rate year using the CMS Input Price Index; and~~

~~2. The change in the Medicare published wage index from the base year to the universal rate year.~~

~~(4) A psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid psychiatric capital cost basis by the number of Medicaid psychiatric patient days in the base year. The Medicaid psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with psychiatric diagnoses with dates of service in the base year. The psychiatric capital per diem rate shall be adjusted as described in Section 10 of this administrative regulation.~~

~~(5) For psychiatric services in an acute care hospital that does not have a Medicare designated distinct part unit, the psychiatric per diem rate shall be the median rate for all psychiatric services in an acute care hospital.~~

~~(6) Payment for an inpatient service provided to a child under age six (6) years shall be in accordance with Section 11(6) of this administrative regulation.~~

~~Section 8.Hospital's Wage Index and Wage Area. (1) A hospital's wage index, used to adjust per diem reimbursement rates established pursuant to Section 7 of this administrative regulation, shall be the wage index published by CMS in the Federal Register on October 1 immediately preceding the universal base rate year.~~

~~(2) For the purpose of applying a wage index, the department shall assign a hospital to:~~

~~(a) The wage area in which it is physically located as originally classified by CMS for the Medicare Program for the base year; or~~

~~(b) The wage area to which a hospital has been reclassified by the Medicare Geographic Classification Review Board for the base year.~~

~~(3) The department shall not consider reclassification of a hospital to a new wage area except during a rebase period.~~

~~Section 9.~~] Budget Neutrality Factors. (1) When rates are rebased, estimated projected reimbursement in the universal rate year [~~for hospitals as described in Sections 3 and 11 of this administrative regulation~~] shall not exceed payments for the same services in the prior year adjusted for inflation using the inflation factor prepared by GII for the universal rate year and adjusted for changes in patient utilization [~~CMS Input Price Index, and adjusted for changes in patient utilization~~].

(2) The estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year shall be estimated from[~~for~~] base year claims. [~~Amounts shall be adjusted for changes in inflation using the CMS Input Price Index and patient utilization.~~]

(3) The estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year shall be estimated from[~~for~~] base year claims.

(4) If the sum of all the acute care hospitals' estimated payments under the methodology used in the universal rate year exceeds the sum of all the acute care hospitals' adjusted estimated payments under the prior year's reimbursement methodology, each hospital's DRG base rate and per diem rate shall be multiplied by a uniform percentage to result in estimated total payments for the universal rate year being equal to total ad-

justed payments in the year prior to the universal rate year.

Section 6. Reimbursement Updating Procedures. (1) The department shall annually, on July 1, use the inflation factor prepared by GII for the universal rate year to inflate a hospital-specific base rate for rate years between rebasing periods.

(2) Except for an appeal in accordance with Section 18 of this administrative regulation, the department shall make no other adjustment.

(3) The department shall rebase DRG reimbursement every four (4) years.

Section 7. Use of a Universal Rate Year. (1) A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.

(2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

Section 8. Cost Reporting Requirements. (1) An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1 and the Supplemental Medicaid Schedule KMAP–4 as follows:

(a) A cost report shall be submitted:

1. For the fiscal year used by the hospital; and

2. Within five (5) months after the close of the hospital's fiscal year; and

(b) Except as follows, the department shall not grant a cost report submittal extension:

1. If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or

2. If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.

(2) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.

(3) A cost report submitted by a hospital to the department shall be subject to audit and review.

(4) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

Section 9. Unallowable Costs.

(1) The following shall not be allowable cost for Medicaid reimbursement:

(a) A cost associated with a political contribution;

(b)1. A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services.

2. A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(c)1. A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity.

2. A cost for a training or educational purpose outside the Commonwealth of

Kentucky shall be allowable.

3. If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.

(2) A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.

(3) The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

Section 10. [~~the following universal rate year reimbursement components shall be adjusted and shall result in estimated payments that are budget neutral:~~

~~(a) DRG relative weights; and~~

~~(b) Periodic direct graduate medical education payment amounts.~~

~~Section 10. Reimbursement Updating Procedures. (1) The department shall rebase per discharge base rates, per diem rates, DRG relative weights, and the following applicable components of the payment rates no less frequently than every three (3) years using the most recent audited cost report and Medicare rate data available to the department:~~

~~(a) Operating rates;~~

~~(b) Capital-related rates;~~

~~(c) Medical education costs;~~

~~(d) Cost-to-charge ratios;~~

~~(e) DRG relative weights; and~~

~~(f) Outlier thresholds.~~

~~(2) Beginning July 1, 2004, the department shall adjust rates annually on July 1 using~~

~~the Medicare DRG base rate in effect October 1 of the preceding year as published in the Federal Register and confirmed with each hospital's fiscal intermediary.~~

~~(3) The department shall adjust per diem rates annually according to the following:~~

~~(a) An operating per diem rate shall be inflated from the midpoint of the previous universal rate year to the midpoint of the current universal rate year using the CMS Input Price Index; and~~

~~(b) A capital cost per diem rate shall not be adjusted.~~

~~(4) Except for an appeal in accordance with Section 29 of this administrative regulation, other adjustments shall not be made.~~

~~Section 11. Payment for Rehabilitation Hospital, Long-term Acute Care Hospital, and Psychiatric Hospitals. (1) Effective April 1, 2003, an inpatient service provided to an eligible Medicaid recipient in a rehabilitation hospital, LTAC hospital, or psychiatric hospital shall continue to be reimbursed at the per diem rate based on the 1999 cost report which was in effect for the rate year beginning July 1, 2002.~~

~~(2) Effective November 1, 2003, an inpatient service provided to an eligible Medicaid recipient in a psychiatric hospital previously designated as a primary referral and service resource for a child in the custody of the Cabinet for Families and Children shall be reimbursed at the per diem rate of $489.75.~~

~~(3) An inpatient service provided to an eligible Medicaid recipient shall be reimbursed by multiplying the hospital's per diem rate by the number of patient days.~~

~~(4) A newly-participating rehabilitation hospital or LTAC shall be paid in accordance with Section 12 of this administrative regulation.~~

~~(5) A psychiatric hospital shall:~~

(a) Except as provided in paragraph (b) of this subsection, have an upper payment limit established on allowable Medicaid costs (except Medicaid capital costs and professional component costs) at the weighted median per diem cost for a hospital in its array; or

(b) If the hospital has Medicaid utilization of thirty-five (35) percent or higher, have an upper limit set at 115 percent of the weighted median per diem cost for a hospital in its array.

(6) For a child under age six (6) years in a disproportionate share hospital or a child under age one (1) in a nondisproportionate share hospital, the following shall apply:

(a) For the first thirty (30) days of inpatient service reimbursed on a per diem basis, payment shall be in accordance with Sections 3, 7, 13, and 21 of this administrative regulation; and

(b) After thirty (30) days, an amount equal to 110 percent of the hospital's per diem rate shall be paid, and the payment shall apply:

1. To an inpatient service determined by the department to be medically necessary:

a. Thirty (30) days after the date of admission of a child; or

b. For a newborn, thirty (30) days from the date of discharge of the mother; and

2. Without regard to length of stay or number of admissions.

Section 12. Payment to a Newly-participating Rehabilitation Hospital or LTAC. (1) A newly-participating rehabilitation hospital or LTAC shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.

(2) A prospective rate shall be set based on the data referenced in subsection (1) of

this section, not to exceed the upper limit for the class.

(3) A prospective rate shall be tentative and subject to settlement at the time the first audited fiscal year end cost report is available to the department.

(4) When a cost report is received and reviewed, a rate shall be set for the rehabilitation hospital or LTAC which shall be adjusted back by DRI to 1997 cost report data and trended forward for two (2) years for inflation by a rate of three (3) percent for the first year and two and eight-tenths (2.8) percent for the second year.

Section 13. Critical Access Hospital. (1) The department shall pay for an inpatient service provided by an in-state critical access hospital to an eligible Medicaid recipient through an interim per diem rate as established by CMS for the Medicare Program.

(2) The effective date of a rate shall be the same as used by the Medicare Program.

(3) A hospital's final reimbursement shall reflect any adjustment made by CMS.

(4) The provisions of Sections 3 through 11 of this administrative regulation shall not apply to a critical access hospital, except:

(a) A hospital shall be required to submit an annual Medicare/Medicaid cost report;

(b) The cost report submitted by a hospital shall be subject to audit and review; and

(c) Total payments made to a hospital under this section shall be subject to the payment limitation in 42 C.F.R. 447.271.

(5) An out-of-state critical access hospital shall be paid the median per diem rate of in-state critical access hospitals.

(6) Payment for a federally defined swing bed in a critical access hospital shall be made in accordance with 907 KAR 1:065.

Section 14. Cost Basis. (1) A hospital per diem rate shall be established relating to

~~allowable Medicaid costs and Medicaid inpatient days.~~

~~(2) An allowable Medicaid cost shall:~~

~~(a) Be a cost allowed after a Medicaid or Medicare audit;~~

~~(b) Be in accordance with 42 C.F.R. Parts 412 and 413;~~

~~(c) Include a hospital provider tax; and~~

~~(d) Not include costs listed in Section 15 of the Medicaid Reimbursement Manual for Hospital Inpatient Services.~~

~~(3) The most recent Medicaid cost report for rehabilitation hospitals, LTAC hospitals, critical access hospitals, psychiatric services in acute care hospitals, and psychiatric hospitals available as of May 1 preceding the current universal rate year shall:~~

~~(a) Be the basis of a prospective payment; and~~

~~(b) Establish the base year.~~

~~(4) A prospective rate shall include both routine and ancillary costs.~~

~~(5) A prospective rate shall not be subject to retroactive adjustment, except for:~~

~~(a) A critical access hospital; or~~

~~(b) A facility with a rate based on unaudited data.~~

~~(6) A facility listed in subsection (5)(a) or (b) of this section shall have its rate revised by the department for the universal rate year when the audited cost report for the base year becomes available to the department.~~

~~(7) Total Medicaid payments to a hospital shall be consistent with the requirements of 42 C.F.R. 447.271.~~

~~(8) An overpayment shall be recouped by the department as follows:~~

~~(a) A provider owing an overpayment shall submit the amount of the overpayment to~~

~~the department; or~~

~~(b) The department shall withhold the overpayment amount from a future Medicaid payment due the provider.~~

~~Section 15. Use of a Universal Rate Year. (1) Except for the first year of the DRG per discharge system, A universal rate year shall be established as July 1 through June 30 of the following year to coincide with the state fiscal year.~~

~~(2) In the first year of the DRG per discharge system, the universal rate year shall be the fifteen (15) month period from April 1, 2003 through June 30, 2004.~~

~~(3) A hospital shall not be required to change its fiscal year to conform with a universal rate year.~~

~~Section 16.~~] Trending of a Cost Report for DRG Re-basing Purposes. (1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or unaudited[~~both audited and unaudited~~], shall be trended to the beginning of the universal rate year to update a hospital's Medicaid cost.

(2) The department shall use the [~~trending factor to be used shall be the~~] inflation factor prepared by GII as the trending factor [~~DRI~~] for the period being trended.

Section 11.[~~17.~~] Indexing for Inflation. (1) After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost in the universal rate year.

(2) The department shall use [~~indexing factor to be applied shall be~~] the inflation factor prepared by GII as the indexing factor [~~DRI~~] for the universal rate year.

Section 12.[~~Section 18. Minimum Occupancy Factor. (1) If a hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:~~

~~(a) Artificially increasing the occupancy factor to the minimum factor; and~~

~~(b) Calculating the capital costs using the calculated minimum occupancy factor.~~

~~(2) The following minimum occupancy factors shall apply:~~

~~(a) A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100 or fewer beds;~~

~~(b) A seventy-five (75) percent minimum occupancy factor shall apply to a hospital with 101 or more beds; and~~

~~(c) A newly-constructed hospital shall be allowed one (1) full universal rate year before a minimum occupancy factor shall be applied.~~

~~Section 19. Reduced Depreciation Allowance. (1) The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty-five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.~~

~~(2) The use of a reduced depreciation allowance shall not be applicable to a psychiatric hospital.~~

~~Section 20.~~] Readmission. (1) An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.

(2) Reimbursement for a readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

Section 13.[~~21.~~] Reimbursement for Out-of-state Hospitals. [~~(1)~~] An acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis[~~for the universal rate year beginning on or after April 1,~~

~~2003~~]. The total per discharge reimbursement shall be the sum of an all-inclusive operating and capital base payment amount, [~~operating payment amount, a capital-related payment amount,~~] and, if applicable, a cost outlier payment amount.

(1)[~~(a)~~] The all-inclusive payment amount:

(a) Shall be based on the patient's diagnostic category; and

(b) For each discharge by multiplying a hospital's all-inclusive base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals pursuant to 2006 Ky Acts. ch. 252.

(2) The all-inclusive base rate:

(a) For an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state shall equal the average all-inclusive base rate paid to in-state children's hospitals.

(b) For an out-of-state rural hospital shall equal the bottom quartile all-inclusive base rate paid to in-state rural hospitals.

(c) For an out-of-state urban hospital shall equal the bottom quartile all-inclusive base rate paid to in-state urban hospitals.

(3) An out-of-state provider shall not be eligible to receive high volume per diem add-on payments, indirect medical education reimbursement or disproportionate share hospital payments.

(4) The department shall make a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to Quality Improvement Organization review and approval.

(a) The department shall determine the cost outlier threshold for an out-of-state claim using the same method used to determine the cost outlier threshold for an in-state claim.

(b) The department shall calculate the estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.

(c) The department shall use the Medicare operating and capital-related cost-to-charge ratios published in the Federal Register for outlier payment calculations as of October 1 of the year immediately preceding the start of the universal rate year.

(d) The outlier payment amount shall equal eighty (80) percent of the amount which estimated costs exceed the discharge's outlier threshold. [~~operating payment amount shall be based on the patient's Medicare DRG classification. An operating payment amount shall be calculated for each discharge by multiplying a hospital's operating base rate by the Kentucky-specific DRG relative weight. A hospital's operating base rate shall be the Medicare national standardized amount, as adjusted by Medicare for each hospital using the Medicare wage index. An operating payment amount for an out-of-state provider shall exclude:~~

~~1. The Medicare DSH operating adjustment factor; and~~

~~2. The Medicare indirect medical education operating adjustment factor.~~

~~(b) The capital-related payment amount shall be made on a per discharge basis. A per discharge payment amount shall be calculated for each discharge by multiplying a hospital's capital-related base rate by the Kentucky-specific DRG relative weight. A~~

~~hospital's capital-related base rate shall be the Medicare federal capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor when applicable and the Medicare geographic adjustment factor as published in the Federal Register. A capital-related payment amount for an out-of-state provider shall exclude:~~

~~1. The Medicare DSH capital adjustment factor; and~~

~~2. The Medicare indirect medical education capital adjustment factor.~~

~~(c) A cost outlier payment shall be made for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG. A cost outlier shall be subject to QIO review and approval.~~

~~1. The cost outlier threshold for an out-of-state claim shall be determined using the same method used to determine the cost outlier threshold for an in-state claim.~~

~~2. The estimated cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be calculated by multiplying the sum of the hospital-specific operating and capital-related mean cost-to-charge ratios by the discharge-allowed charges.~~

~~3. The outlier payment amount shall be eighty (80) percent of the amount that estimated costs exceed the discharge's outlier threshold.~~

~~(2) An acute care out-of-state hospital shall be reimbursed for an inpatient psychiatric service on a fully-prospective per diem basis for the universal rate year beginning on or after April 1, 2003~~.

~~(a) Reimbursement for an inpatient psychiatric service shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.~~

~~(b) A psychiatric per diem rate shall be the sum of a psychiatric operating per diem rate and a psychiatric capital per diem rate.~~

~~1. The psychiatric operating per diem rate shall be the median operating cost, excluding graduate medical education, per day for all in-state acute care hospitals that have licensed psychiatric beds according to 902 KAR 20:180.~~

~~2. The psychiatric capital per diem rate shall be the median psychiatric capital per diem rate for all in-state acute care hospitals that have licensed psychiatric beds according to 902 KAR 20:180.~~

~~(3) Reimbursement for a service in an out-of-state rehabilitation hospital shall be determined by multiplying a hospital's rehabilitation per diem rate by the number of allowed patient days.~~

~~(4) A rehabilitation per diem rate shall be the median rehabilitation per diem rate for all in-state rehabilitation hospitals.~~

~~(5) Reimbursement for a service in an out-of-state psychiatric hospital shall be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.~~

~~(6) The department shall apply the requirements of 42 C.F.R. 447.271 on a claim-specific basis to payments made under this section.~~]

Section 14.[~~22.~~] Supplemental Payments. (1) In addition to a payment based on a rate developed under Section 2[~~3~~] of this administrative regulation, the department shall make quarterly supplemental payments to:

(a) A hospital that qualifies as a nonstate pediatric teaching hospital in an amount:

1. Equal to the sum of the hospital's Medicaid shortfall for Medicaid recipients under

the age of eighteen (18) plus an additional $250,000 ($1,000,000 annually); and

2. Prospectively determined by the department with an end of the year settlement based on actual patient days of Medicaid recipients under the age of eighteen (18);

(b) A hospital that qualifies as a pediatric teaching hospital and additionally meets the criteria of a Type III hospital in an amount:

1. Equal to the difference between payments made in accordance with Sections 2, 3 and 4 [~~3, 4, 5, and 7~~] of this administrative regulation and the amount allowable under 42 C.F.R. 447.272, not to exceed the payment limit as specified in 42 C.F.R. 447.271;

2. That is prospectively determined with no end of the year settlement; and

3. Based on the state matching contribution made available for this purpose by a facility that qualifies under this paragraph; and

(c) A hospital that qualifies as an urban trauma center hospital in an amount:

1. Based on the state matching contribution made available for this purpose by a government entity on behalf of a facility that qualifies under this paragraph;

2. Based upon a hospital's proportion of Medicaid patient days to total Medicaid patient days for all hospitals that qualify under this paragraph;

3. That is prospectively determined with an end of the year settlement; and

4. That is consistent with the requirements of 42 C.F.R. 447.271.

(2) The department shall make quarterly supplemental payments to the Appalachian Regional Hospital system in an amount that is equal to the lesser of:

(a) The difference between what the department pays for inpatient services pursuant to Section 2, 3 and 4 of this administrative regulation and what Medicare would pay for inpatient services to Medicaid eligible individuals; or

(b) $7.5 million per year in aggregate.

(3) A quarterly payment to a hospital in the Appalachian Regional Hospital System shall be based on its Medicaid claim volume in comparison to the Medicaid claim volume of each hospital within the Appalachian Regional Hospital System.

(4) A supplemental payment made in accordance with subsection (2) of this section shall be:

(a) For a service provided on or after July 1, 2005; and-

(b) Subject to the availability of coal severance funds that supply the state's share to be matched with federal funds.

(5)[~~;~~

~~(d) A hospital that qualifies as a psychiatric access hospital in an amount:~~

~~1. Equal to a hospital's uncompensated costs of providing services to Medicaid recipients and individuals not covered by a third-party payor, not to exceed $6 million annually; and~~

~~2. That is consistent with the requirements of 42 C.F.R. 447.271;~~

~~(e) A nonstate government-owned hospital as defined in 42 C.F.R. 447.272(a)(2) that has entered into an intergovernmental transfer agreement with the Commonwealth in an amount equal to the lessor of:~~

~~1. The difference between the payments made in accordance with Section 3 of this administrative regulation and the maximum amount allowable under 42 C.F.R. 447.272;~~

~~or~~

~~2. The difference between the payments made in accordance with Section 3 of this administrative regulation and an amount consistent with the requirements of 42 C.F.R.~~

~~447.271; and~~

~~(f) A private, nongovernment owned or operated hospital in an amount:~~

~~1. Proportional to its Medicaid cost as compared to the total Medicaid costs of all hospitals qualifying under this paragraph;~~

~~2. Not to exceed its Medicaid shortfall; and~~

~~3. Subject to available funds in accordance with an intergovernmental transfer agreement under paragraph (e) of this subsection and Section 3 of 907 KAR 1:015. Available funds shall be:~~

~~a. An amount equal to fifty (50) percent of the payments received by hospitals under paragraph (e) of this subsection after deducting the nonfederal share of the funds, less the total Medicaid shortfall of hospitals participating under paragraph (e) of this subsection; and~~

~~b. Matched with federal funds.~~

~~(2)~~] An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility.

(6)[~~(3)~~] For the purpose of this section of this administrative regulation, Medicaid patient days shall not include days for a Medicaid recipient eligible to participate in the state's Section 1115 waiver as described in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver).

(7)[~~(4)~~] A payment made under this section of this administrative regulation shall not duplicate a payment made via 907 KAR 1:820, Disproportionate share hospital distributions.

(8) [~~under Section 23 of this administrative regulation.~~

(~~5) A payment made in accordance with subsection (1)(d) and (e) of this section shall be for a service provided on or after April 2, 2001.~~

~~(6) A payment made in accordance with subsection (1)(f) of this section shall be for a service provided on or after November 5, 2001.~~

~~(7)~~] A payment made in accordance with this section of this administrative regulation shall be in compliance with the limitations established in 42 C.F.R. 447.272.

(9)[~~(8)~~] A supplemental payment for a DRG 675 - 680[~~DRGs 385 through 390~~] shall be made to an in-state high intensity level II neonatal center.

Section 15. Certified Public Expenditures. (1) The department shall reimburse an in-state public government-owned or operated hospital the full cost of an inpatient service via a certified public expenditure (CPE) contingent upon approval by the Centers for Medicare and Medicaid Services (CMS).

(2) To determine the amount of costs eligible for a CPE, a hospital's allowed charges shall be multiplied by the hospital's operating cost-to-total charges ratio.

(3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

(4)(a) Subsequent to a cost report being submitted to the department and finalized, a CPE shall be reconciled with the actual costs reported to determine the actual CPE for the period.

(b) If any difference remains, the department shall reconcile any difference with the provider.

Section 16. Access to Subcontractor's Records. If a hospital has a contract with a

subcontractor for services costing or valued at $10,000 or more over a twelve (12) month period:

(1) The contract shall contain a provision granting the department access:

(a) To the subcontractor's financial information; and

(b) In accordance with 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation; and

(2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

Section 17. New Provider, Change of Ownership, or Merged Facility.

(1) If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the rate in effect at the time of the change of ownership.

(2)(a) Until a fiscal year end cost report is available, a newly constructed or newly participating hospital shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification.

(b) During the projected rate year, the budget shall be adjusted if indicated and justified by the submittal of additional information.

(3) In the case of two (2) or more separate entities that merge into one (1) organization, the department shall:

(a) Merge the latest available data used for rate setting;

(b) Combine bed utilization statistics, creating a new occupancy ratio;

(c) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs;

(d) Compute on a weighted average the rate of increase control applicable to each

entity, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting; and

(e)1. Require each provider to submit a cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.

2. A cost report for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 8 of this administrative regulation.

Section 18. Appeals. (1) An administrative review shall not be available for the following:

(a) A determination of the requirement, or the proportional amount, of a budget neutrality adjustment in the prospective payment rate; or

(b) The establishment of:

1. Diagnostic related groups;

2. The methodology for the classification of an inpatient discharge within a DRG; or

3. An appropriate weighting factor which reflects the relative hospital resources used with respect to a discharge within a DRG.

(2) An appeal shall comply with the review and appeal provisions established in 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions.

Section 19. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) The "Supplemental Medicaid Schedule KMAP-1"; January 2007 edition; and

(b) The "Supplemental Medicaid Schedule KMAP-4", January 2007 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. [~~a hospital with a Level II neonatal center that:~~

~~(a) Is licensed for a minimum of twenty-four (24) neonatal level II beds;~~

~~(b) Has a minimum of 1,500 Medicaid neonatal level II patient days per year;~~

~~(c) Has a gestational age lower limit of twenty-seven (27) weeks; and~~

~~(d) Has a full-time perinatologist on staff.~~

~~Section 23. Disproportionate Share Hospital Payment. (1) A disproportionate share hospital payment shall be made to a qualified hospital based upon available funds in accordance with KRS 205.640.~~

~~(2) For DSH calculation purposes, a per diem used shall be the per diem in effect March 31, 2003.~~

~~(3) A payment to a Type I hospital or a Type II hospital shall:~~

~~(a) Be a prospective amount;~~

~~(b) Be distributed based upon a hospital's proportion of indigent care; and~~

~~(c) Not be subject to settlement or revision based on a change in utilization during the year to which it applies.~~

~~(4) The cost of indigent care for the purpose of making a payment to a Type I hospital or Type II hospital shall be determined by:~~

~~(a) Calculating the costs of inpatient indigent care by multiplying each day of indigent care provided by the facility by its Medicaid per diem rate on file March 31, 2003; and~~

~~(b) Multiplying each facility's indigent outpatient charges by the most recent cost-to-~~

charge ratio used by the Department of Labor in accordance with 803 KAR 25:091.

(5) Distributions to a Type III hospital shall:

(a) Be based on a facility's historical proportion of the costs of services to Medicaid recipients, minus the amount paid by Medicaid under Sections 3, 4 and 18 of this administrative regulation, plus the costs of services to indigent and uninsured patients minus any payments made on behalf of indigent and uninsured patients;

(b) Be a prospective amount and shall not be subject to settlement or revision based on a change in utilization during the year to which it applies;

(c) Be made on an annual basis; and

(d) Be contingent upon a facility providing up to 100 percent of matching funds to receive federal financial participation for payment under this subsection.

(6) Distributions to a Type IV hospital shall:

(a) Be equal to the costs of services provided to indigent patients minus any payments made on behalf of an indigent individual;

(b) Be proportionally reduced by the department if the cost exceeds available funds; and

(c) Be made annually.

(7) For dates of service beginning December 2, 2003, A supplemental Medicaid shortfall DSH payment shall be added per paid claim for inpatient hospital services reimbursed in accordance with Section 3 of this administrative regulation.

(a) The supplemental payment shall be in effect until whichever of the following events occurs first:

1. The maximum total amount paid in accordance with this subsection reaches $20

~~million; or~~

~~2. The date of June 30, 2004.~~

~~(b) The supplemental payment shall not apply to:~~

~~1. A claim that is paid at a rate of zero dollars;~~

~~2. A claim for a psychiatric service; or~~

~~3. A claim for a transplant.~~

~~Section 24. Indigent Care Eligibility. (1) Prior to billing a patient and prior to submitting the cost of a hospital service to the department as uncompensated, a hospital shall use the indigent care eligibility form, Application for Disproportionate Share Hospital Program (DSH-001), to assess a patient's financial situation to determine if:~~

~~(a) Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or~~

~~(b) A patient meets the indigent care eligibility criteria.~~

~~(2) An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance (Medicaid or KCHIP) within thirty (30) days of completing the DSH-001 form at the hospital.~~

~~Section 25. Indigent Care Eligibility Criteria. (1) A hospital shall receive funding for an inpatient or outpatient medical service provided to an indigent patient under the provisions of Sections 23 and 24 of this administrative regulation if the following apply:~~

~~(a) The patient is a resident of Kentucky;~~

~~(b) The patient is not eligible for Medicaid or KCHIP;~~

~~(c) The patient is not covered by a third-party payor;~~

~~(d) The patient is not in the custody of a unit of government that is responsible for~~

~~coverage of the acute care needs of the individual;~~

~~(e) The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:~~

~~1. The patient;~~

~~2. The patient's spouse;~~

~~3. The minor's parent or parents living in the home; and~~

~~4. Any minor living in the home;~~

~~(f) A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;~~

~~(g) Countable resources of a family unit shall not exceed:~~

~~1. $2,000 for an individual;~~

~~2. $4,000 for a family unit size of two (2); and~~

~~3. Fifty (50) dollars for each additional family unit member;~~

~~(h) Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and~~

~~(i) The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.~~

~~(2) Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:~~

~~(a) Income received during the twelve (12) months preceding the month of receiving a service; or~~

~~(b) The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four~~

~~(4).~~

~~(3) A work expense for a self-employed patient shall be deducted from gross income if:~~

~~(a) The work expense is directly related to producing a good or service; and~~

~~(b) Without it the good or service could not be produced.~~

~~(4) A hospital shall notify the patient or responsible party of his eligibility for indigent care.~~

~~(5) If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination~~.

~~Section 26. Indigent Care Eligibility Determination Fair Hearing Process. (1) If a hospital determines that a patient does not meet indigent care eligibility criteria as established in Section 25 of this administrative regulation, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.~~

~~(2) If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.~~

~~(3) A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:~~

~~(a) Review evidence regarding the indigent care eligibility determination;~~

~~(b) Cross-examine witnesses regarding the indigent care eligibility determination;~~

~~(c) Present evidence regarding the indigent care eligibility determination; and~~

~~(d) Be represented by counsel.~~

~~(4) A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:~~

~~(a) The patient or responsible party who requested the fair hearing; and~~

~~(b) The department.~~

~~(5) A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.~~

~~(6) A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with KRS 13B.140.~~

~~Section 27. Indigent Care Reporting Requirements. (1) On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data.~~

~~(2) If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.~~

~~Section 28. Retrospective Review. (1) A claim paid in accordance with Section 3 of this administrative regulation shall be subject to retrospective review by the QIO.~~

~~(2) An amount paid that is found to be paid in error shall be recouped by the department in the next payment cycle.~~

~~(3) A payment that has been recouped by the department shall not be subject to administrative review.~~

~~Section 30. Incorporation by Reference. (1) The "Medicaid Reimbursement Manual for Hospital Inpatient Services, November 2003 Edition", is incorporated by reference.]~~

~~(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.~~]

907 KAR 1:013E

REVIEWED:

Date

Shawn M. Crouch, Commissioner
Department for Medicaid Services

APPROVED:

Date

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:013E
Cabinet for Health Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-6204 or Barry Ingram (502) 564-5969

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes inpatient hospital diagnostic related group (DRG) reimbursement provisions.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish inpatient hospital DRG reimbursement provisions.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing inpatient hospital DRG reimbursement provisions.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing inpatient hospital DRG reimbursement provisions.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment narrows the administrative regulation's domain to inpatient hospital DRG reimbursement. It implements a new DRG reimbursement model resulting from discussions with the Kentucky Hospital Association (KHA) and in accordance with KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to implement a revised reimbursement methodology which reimburses for inpatient hospital care in accordance with KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.
(c) How the amendment conforms to the content of the authorizing statutes: The amendment modifies inpatient hospital reimbursement within the extent and scope authorized by state law (including KRS 142.303, 205.638 and 2006 Ky Acts ch. 252) and federal law via a nationally-recognized DRG model.
(d) How the amendment will assist in the effective administration of the statutes: The amendment modifies inpatient hospital reimbursement within the extent and scope authorized by state law (including KRS 142.303, 205.638 and 2006 Ky Acts ch. 252) and federal law via a nationally-recognized DRG model.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All inpatient

hospitals, approximately seventy (70), reimbursed via the DRG methodology will be affected.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The regulated entities will not be required to take any action to comply with the administrative regulation. Presumably they may educate staff regarding the reimbursement changes; however, no new requirements are mandated via this administrative regulation.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is foreseen other than administrative cost a hospital may experience in educating staff about the reimbursement changes.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): No new requirements are mandated via this administrative regulation and provider reimbursement will change in some respects. Providers, already reimbursed via a DRG methodology, will be reimbursed via a revised DRG model.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: The amendment is expected to cost the Department for Medicaid Services (DMS) approximately $8.5 million ($5.91 million federal funds; $2.59 million state funds) annually.
(b) On a continuing basis: The amendment is expected to cost DMS approximately $8.5 million ($5.91 million federal funds; $2.59 million state funds) annually.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX, matching funds of general fund appropriations and hospital provider tax funds pursuant to KRS 142.303, 205.638 and 2006 Ky Acts ch. 252.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:013E Contact Person: Stuart Owen (502)-564-6204
or Barry Ingram (502) 564-5969

1. Federal statute or regulation constituting the federal mandate.
   42 CFR Chapter 412, Chapter 413 and 447.200, 447.250, 447.271, and 447.272 address inpatient hospital reimbursement provisions.

2. State compliance standards.

   KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 addresses Medicaid reimbursement. 2006 Ky Acts ch. 252, KRS 142.303 and 205.638 address the utilization of hospital provider tax revenues to enhance inpatient hospital reimbursement.

3. Minimum or uniform standards contained in the federal mandate.

   Medicaid agency payments to providers must be sufficient to enlist enough providers so that Medicaid services are available to recipients at least to the same extent that comparable services are available to the general population. Payments for hospital services should be rates that the State finds, and makes assurances satisfactory to the United States Health and Human Services Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

   This administrative regulation does not impose stricter, than federal, requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

   This administrative regulation does not impose stricter, than federal, requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:013E Contact Person: Stuart Owen (502)-564-6204 or Barry Ingram (502) 564-5969

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X_ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect county-owned hospitals as well as state university teaching hospitals.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by KRS 142.303, 205.520, 205.638, 2006 Ky Acts ch. 252, 42 CFR 412 and 413.

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment is not expected to generate additional revenue for state government or state government entities but is expected to generate approximately $2.0 million ($1.4 million federal funds; $0.6 million state funds) for county-owned hospitals.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment is not expected to generate additional revenue for state government or state government entities but is expected to generate approximately $2.0 million ($1.4 million federal funds; $0.6 million state funds) for county-owned hospitals.

   (c) How much will it cost to administer this program for the first year? The amendment is expected to cost the Department for Medicaid Services (DMS) approximately $8.5 million ($5.91 million federal funds; $2.59 million state funds) annually.

(d) How much will it cost to administer this program for subsequent years? The amendment is expected to cost the Department for Medicaid Services (DMS) approximately $8.5 million ($5.91 million federal funds; $2.59 million state funds) annually.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: No additional expenditures are necessary to implement this amendment.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:013E, Diagnostic related group (DRG) inpatient hospital reimbursement

Summary of Material Incorporated by Reference

(1) The “Supplemental Medicaid Schedule KMAP-1”; January 2007 edition is being incorporated by reference and used to document hospital costs, legal fees, political contributions and out-of-state travel and is a one (1) page form.

(2) The “Supplemental Medicaid Schedule KMAP-4”, January 2007 edition is being incorporated by reference and is used to document miscellaneous care or related including whether non-emergency obstetric services are offered, age threshold (under or over eighteen (18)) of predominant number of individuals served, Medicaid revenues, total revenues, state and local government revenues, charges attributable to charity care, and total inpatient charges. The form consists of one (1) page.

(3) The "Medicaid Reimbursement Manual for Hospital Inpatient Services”, November 2003 Edition, is being deleted from the material incorporated by reference.